Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name:
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number:
M4-11-0310-01

MDFR Received Date
SEPTEMBER 20, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I receive a letter back in Nov 2010 stating they would pay for my RX's. I sppoike with the Adjuster: Jeanna Russell in Nov. 2010. Still have not receive payment fax over new RX log from Sept thu Nov 2010. Still no act.".

Amount in Dispute: $1,009.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charges submitted are currently being reviewed and processed for payment from our Branch office."

Response Submitted by: Liberty Mutual Insurance Co., 2875 Browns Bridge Rd., Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 18, 2008 through September 17, 2009	Out-of-Pocket expenses incurred for prescription medications – Untimely submitted	$569.58	$0.00
June 21, 2010 through September 14, 2010	Out-of-Pocket expenses incurred for prescription medications – Timely submitted	$440.40	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured employees to submit workers' compensation out-of-pocket expenses to the insurance carrier for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes: Explanation of Benefits were not submitted by either party.

Issues

1. Did the requestor submit the out-of-pocket expenses for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor receive reimbursement from the respondent for the disputed dates of service?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Texas Administrative Code §133.307(c)(1)(A), dates of service May 18, 2008 through September 17, 2009 were not submitted to Medical Fee Dispute Resolution within one year after the dates of service in dispute. Therefore, these dates of service are not eligible for review by the Division's Medical Fee Dispute Resolution section. Dates of service June 21, 2010 through September 14, 2010 were submitted timely; therefore, these dates of service are eligible for review by Medical Fee Dispute Resolution.
2. The respondent submitted payment summaries showing payment has been made. Check number 94540397 in the amount of $389.55 was issued for dates of service May 1, 2008 through June 21, 2010; check number 94398672 in the amount of $401.44 was issued for dates of service June 4, 2009 through September 17, 2009; check number 95639656 in the amount of $154.00 was made for date of service September 19, 2010; check number 94421372 in the amount of $377.00 was made for dates of service September 15, 2010 through November 15, 2010. The respondent also submitted correspondence from the injured worker to a Mr. Kirby Simm, dated January 25, 2011 which states in part, "I did receive two checks one for $407, $377, as you look at the forms you will see it is more. Thanks!"
3. Review of the submitted documentation by both parties shows the disputed dates of service, including the untimely dates of service, were reimbursed by the respondent.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 11, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.